BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **GOVINDASAMY SANKAR, M.D.** Holder of License No. 33633 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-10-1440A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 8, 2011. Govindasamy Sankar, M.D. ("Respondent") appeared before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 33633 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-10-1440A after receiving a complaint regarding Respondent's care and treatment of a 60 year-old male patient ("CG") alleging that Respondent inappropriately prescribed CG controlled substances.

4. In March 2005, CG established care with Respondent's partner. Approximately four years later, in October 2009, Respondent assumed care of CG and continued his Methadone medication at a dose of 40mg with prescriptions provided on a monthly basis.

5. On January 2, 2010, CG sustained a fracture of the C3 facet without spinal injury and he was treated in the emergency room. Respondent later saw CG, referred him to neurosurgery and continued his Methadone prescription.

6. CG was seen by neurosurgery, in which a repeat CT scan was conducted that showed healing of the C2-3 facet joint. Neurosurgery recommended a bone scan, which CG refused to schedule.

7. On February 5, 2010, Respondent saw CG and refilled his Methadone.

8. On March 8, 2010, CG had a syncopal episode and emergency medical services were contacted. He had a witnessed run of tachycardia with a decreased level of consciousness. CG was given Amiodarone followed by synchronized cardioversion and he was treated with defibrillation, Amiodarone, Magnesium, a Lidocaine Bolus and drip, and Lopressor.

9. CG was admitted to the hospital under the care of Respondent and had a urine drug screen positive for THC and negative for opiates.

10. An EKG showed SR with a prolonged PR and a RBBB. Respondent incorrectly documented CG's prescription information on his dictated history and physical and mistakenly stated that CG had undergone a coronary angiogram.

11. Respondent ordered Methadone, daily Fluoxetine and Sorbitol. He did not address the abnormal drug screen results.

12. The cardiologist noted a prior cardiac catheterization and planned for myocardial profusion imaging and serial EKGs and enzymes. No cardiac catheterization was performed. CG's potassium was corrected and Lidocaine was discontinued. A Thallium stress test showed a large inferior defect, and a cardiac catheterization later showed normal coronary arteries. The cardiologist noted the false positive Thallium scan and recommended medical management and drug rehabilitation.

13. CG was discharged on March 13, 2010 and was advised to decrease the Methadone dose.

14. On March 29, 2010, Respondent saw CG with a complaint of burning during urination and a decreased urine flow. He prescribed Methadone and Ciprofloxin.

15. CG was seen in the emergency room requesting a refill of Methadone on July 13, 2010 and reported that he had changed physicians. CG saw Respondent a week later for a pain medication refill, and Methadone 10 mg #270 was prescribed. That evening CG went into cardiac arrest and was found pulseless and apneic with CPR in progress. CG was found to be in ventricular fibrillation and ventricular tachycardia. He was defibrillated and went into asystole. Resuscitation efforts were unsuccessful and CG was later pronounced dead in the emergency room.

16. The Medical Examiner opined that CG's death was due to Methadone intoxication, with Hepatitis C as a significant contributing factor.

17. At the Formal Interview, Respondent observed that the present case was the first complaint brought against him in nearly 34 years of practice. He also noted that the autopsy report on the patient pointed to morphine in his blood stream, but there was nothing in the pharmacy survey or the emergency room records from July 13 indicating where the morphine came from.

18. During their deliberations, members of the Board expressed concern with the inadequacy of Respondent's medical records as well as his deviations from the standard of care. Of particular concern was the fact that Respondent reinstituted the patient's Methadone without ascertaining the amounts and types of opiates that patient was on at a time when he had not seen the patient for three months. The Board concluded that Respondent's conduct had the potential to cause the harm that occurred to the patient.

19. The standard of care for managing a patient's chronic pain with Methadone requires a physician to address current pain medication use when the patient has not been prescribed Methadone by the provider in more than three months.

20. Respondent deviated from the standard of care by failing to ascertain the amounts and types of narcotic medications that CG had used for treatment of his pain while not receiving monthly Methadone from Respondent.

21. The standard of care requires a physician to address findings of an illegal substance on a urine drug screen with a patient who is receiving narcotics for chronic pain and who has previously signed a pain medication management agreement that states positive tests for any illegal substances will result in dismissal.

22. Respondent deviated from the standard of care by failing to address a urine drug screen that was positive for THC during CG's March 2010 hospitalization.

23. There was potential for Methadone overdose with cardiac arrhythmias including ventricular fibrillation and ventricular tachycardia.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(e) ("[f]ailing or refusing to maintain adequate medical records on a patient.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT

1. Respondent is issued a Letter of Reprimand.

2. Respondent shall, within six months, complete 15 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in opioid prescribing and provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for biennial renewal of his medical license. Respondent's failure to complete the CME will subject him to future disciplinary action by the Board. A.R.S. § 32-1401(27)(r).

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED AND EFFECTIVE this 11th day of AUGUST, 2011.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

EXECUTED COPY of the foregoing mailed this 11th day of August, 2011 to:

Paul Giancola
Snell & Wilmer, LLP
400 E. Van Buren
Phoenix, AZ 85004
(Attorney for Respondent)

ORIGINAL of the foregoing filed this 11th day of August, 2011 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

_____
Arizona Medical Board Staff

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **GOVINDASAMY SANKAR, M.D.** Holder of License No. **33633** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-10-1440A **ORDER DENYING MOTION FOR REHEARING OR REVIEW** (Letter of Reprimand)

At its public meeting on October 5, 2011, the Arizona Medical Board ("Board") considered a Petition for Rehearing or Review filed by Govindasamy Sankar, M.D. ("Respondent"). Respondent requested the Board rehear or review its August 11, 2011, Findings of Fact, Conclusions of Law and Order for Letter of Reprimand in Case no. MD-10-1440A. The Board voted to deny the Respondent's Petition for Rehearing or Review upon due consideration of the facts and law applicable to this matter.

ORDER

IT IS HEREBY ORDERED that:

Respondent's Petition for Rehearing or Review is denied. The Board's August 11, 2011, Findings of Fact, Conclusions of Law and Order for Letter of Reprimand in Case no. MD-10-1440A is effective and constitutes the Board's final administrative order.

RIGHT TO APPEAL TO SUPERIOR COURT

Respondent is hereby notified that he has exhausted his administrative remedies. Respondent is advised that an appeal to Superior Court in Maricopa County may be taken from this decision pursuant to title 12, chapter 7, article 6 of Arizona Revised Statutes.

DATED this 17th day of October, 2011.

THE ARIZONA MEDICAL BOARD

By _____
LISA WYNN
Executive Director

ORIGINAL of the foregoing filed this 17th day of October, 2011 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 17th day of October, 2011 to:

Paul Giancola
Snell & Wilmer, LLC
One Arizona Center
400 E. Van Buren
Phoenix, AZ 85004-2202